Enrollment Form: Town of Westford - Active Employee

Employer Use Only: Please fax to Group Premium Enrollment Services **402-997-1994**

Group Premium and Enrollment Services
Underwritten by: **United of Omaha Life Insurance Company**

To Be Completed By Employer Or Plan Sponsor

Employer's Company Name: Town of Westford **City:** Westford **State:** MA **Zip:** 01886

Location Code: _____

Sub Group Name: ☐ **Town Employee** ☐ **School Employee**

G000237D _____ _____ _____/_____/_____
Group I.D. **Sub Group I.D.** **Class** **Effective Date**

To Be Completed By Employee (Please Print)

Social Security Number: _____-_____-_____ **Occupation:** _____

Name: _____ _____ ___
Last First M.I

Birth Date: _____/_____/_____ **Sex:** ☐ Male ☐ Female
Month Day Year

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow

Hire Date: _____/_____/_____ **Hours worked per week:** _____
Month Day Year

Full-Time Employment Date: _____/_____/_____
Month Day Year

Street Address: _____ **Zip Code:** _____

City: _____ **State:** _____

Home Phone: _____ **Work Phone:** _____

Employee Election:

	Yes	No	Benefit Amount
Life/AD&D	☐	☐	$10,000

Benefit Amount: Please indicate the benefit amount applicable for the coverage(s) that you selected.

Beneficiary for Death Benefits – Right to Change Beneficiary is Reserved to the Insured**.**
(If more than one beneficiary is named, the beneficiaries shall share equally unless otherwise stated below.)

Primary Beneficiary				**Secondary Beneficiary**			
Last Name	First	MI	Relationship to Insured	Last Name	First	MI	Relationship to Insured

Instructions: Application must be made within 31 days from the date the employee becomes eligible (or as otherwise stated in the plan). If plan is contributory, form **MUST** be signed and dated to authorize payroll deductions.

I represent that the information I have provided in this Enrollment Form is complete, true and accurate, to the best of my knowledge.

Signature of Employee_____ **Date**_____/_____/_____

Applicable to Life Plans:
For Residents of New York: Your employer may include a Living Care, (Accelerated Death Benefit) in your plan. If so, there is no additional premium charge associated with the Living Care benefit. Receipt of Living Care (Accelerated Death Benefit) may affect eligibility for public assistance programs and may be taxable.

THIS FORM MUST BE FILLED OUT BY ALL EMPLOYEES